

Changes to the State's HCBS Waivers Effective 3/27/2015



PRESENTED BY DIDD LEADERSHIP

PREPARED BY

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Presentation Notes

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- You should be able to hear the presenter through your speakers or headphones. If not, please try rebooting first.
- Questions should be entered in the Chat Box on the left of the screen and will be addressed during the presentation.
- This presentation will be posted on the DIDD Website: >For Providers>Waiver Amendments and Waiver Rates and Services.
- A compilation of the questions will be gathered and developed into an FAQ which will be posted on the DIDD Website: >For Providers>Waiver Amendments and Waiver Rates and Services.
- http://www.tn.gov/didd/provider_agencies/index.shtml



Today's Presentation Will

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- Cover the waiver renewal timeline briefly.
- Briefly review federal rules:
 - Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings/Person Centered Planning (PCP) Final Rule.
 - Department of Labor (DOL) Fair Labor Standards Act (FLSA) Final Rule.
- Cover changes to the waivers, focusing on those that impact providers.



Today's Presentation Will

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- Cover substantive changes affecting providers to the waivers in detail.
 - Individual Cost Neutrality Cap on the Statewide Waiver.
 - New flexibility in residential services.
 - Changes to the Waiver Services definitions.
 - Added safeguards for Persons Supported.
 - Modified the Quality Management Strategy, per CMS requirements.
 - Minor updates to the Financial Accountability Appendix.
- Note that if a service was not included in this presentation, it means there were not any substantive changes affecting providers.
- Cover new requirements for providers, related to these changes, in detail.

Renewal and Amendment Timelines

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- The public input period on changes to the State's HCBS waivers was initiated in the summer of 2014.
- The public input was collected and reviewed by TennCare and DIDD and incorporated in the State's renewal and amendment applications, to the extent possible.
- The waiver renewal applications (Arlington and Statewide) and amendment application (Self-Determination) were submitted to CMS on October 1, 2014.



Renewal and Amendment Timelines

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- The Arlington Waiver was renewed and renamed the Comprehensive Aggregate Cap (CAC) Waiver effective 3/27/2015.
- The Self-Determination Waiver was amended for consistency with the other waivers effective 3/27/2015.
- The Statewide Waiver was renewed effective 3/27/2015.

Changes Effective



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- Individual Cost Neutrality Cap will be applied to people currently enrolled in the Statewide Waiver.
 - For existing waiver enrollees, the individual cost neutrality cap will be effective 30 days after the date of the 30-day advance notice that will be mailed to all individuals currently enrolled in the Statewide Waiver.
- Individuals whose current services exceed the individual cost neutrality cap will be transitioned to the CAC Waiver.

Changes Effective



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- The transition of individuals to the CAC waiver, as applicable, will be effective upon the expiration of the 30-day advance notice period.
- Other revisions are effective immediately upon CMS approval, unless otherwise indicated.

Federal Rules

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**CENTERS FOR MEDICARE AND MEDICAID
SERVICES (CMS)
HCBS SETTINGS AND
PERSON CENTERED PLANNING FINAL RULE**

**DEPARTMENT OF LABOR (DOL)
FAIR LABOR STANDARDS ACT FINAL RULE**

CMS Final Rule

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**HCBS SETTINGS AND
PERSON CENTERED PLANNING RULE**

CMS Final Rule: HCBS Settings

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- The final rule addresses several sections of federal law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services.

CMS Final Rule: HCBS Settings

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- In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid reimbursed HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

CMS Final Rule: Person Centered Planning

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- CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) must be developed through a person-centered planning process that addresses clinical as well as long-term services and support needs in a manner that reflects individual preferences and goals.

CMS Final Rule: Person Centered Planning

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- The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.

CMS Final Rule: Person Centered Planning

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- The rule describes the minimum requirements for person centered plans developed through this process, including that the process results in a person centered plan with individually identified goals and preferences.

Changes Related to the HCBS Settings and PCP Rules



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- The State has modified service definitions and other applicable waiver sections in order to ensure compliance with the Final Rule released by CMS on HCBS Settings and Person Centered Planning requirements.

HCBS Settings Rule

New Language Added throughout the Waiver

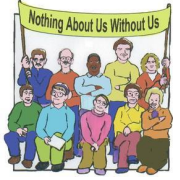


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- “...services are selected by the person supported ... and which supports the person’s independence and full integration into the community, ensures the person’s choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c) of the Social Security Act, except as supported by the individual’s specific assessed need and set forth in the person-centered Individual Support Plan (ISP).”

Person Centered Planning Rule

New Language Added throughout the Waiver



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- “All individual goals and objectives, along with needed supports shall be established through the person centered planning process and documented in the person-centered ISP and shall include opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources, as applicable based on the needs and preferences of the individual.”

Rights to Privacy, Dignity, Respect and Freedom

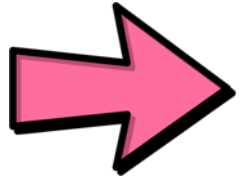
New Language Added throughout the Waiver



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- Supports shall be provided in a manner which ensures an individual's rights of privacy, dignity, respect and freedom from coercion and restraint; and which optimizes individual initiative, autonomy, and independence in making life choices.

CMS Guidance on Final Rule



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- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Department of Labor (DoL) Final Rule

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FAIR LABOR STANDARDS ACT (FLSA)

DoL Fair Labor Standards Act (FLSA)

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- The Department of Labor published a Final Rule on October 1, 2013 extending minimum wage and overtime pay protections under the Fair Labor Standards Act (“FLSA”) to many direct care workers (such as home health aides, personal care assistants, and workers in similar occupations) who provide essential home care assistance to people with disabilities and older adults.
- Specifically, the rule narrowed the “companionship services” that were exempt from overtime pay in the FLSA.
- The Rule took effect on January 1, 2015

DoL Final Rule

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- The Final Rule, contains several significant changes from the prior regulations, including:
 - (1) the tasks that comprise “companionship services” for purposes of the exemption are narrowed; and
 - (2) the exemptions for companionship services and live-in domestic service employees are limited to the individual, family, or household using the services; and
 - (3) the record keeping requirements for employers of live-in domestic service employees are revised.

Litigation Involving DoL Final Rule

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- On December 22, 2014, the U.S. District Court for the District of Columbia vacated the third party regulation, which DoL had amended in the Home Care rule to remove the third party overtime and minimum wage exemptions.
- On January 14, 2015, this same Court vacated the Home Care rule's revised definition of companionship services.

Litigation Involving DoL Final Rule

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- DoL strongly disagreed with the District Court's orders. On January 22, 2015, DoL filed an appeal in the U.S. Court of Appeals for the District of Columbia Circuit to overturn the orders of the D.C. District Court.
- The D.C. Court of Appeals has granted an expedited appeal and a decision is anticipated in summer 2015.

Litigation Involving DoL Final Rule

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- It is DoL's opinion that the D.C. District Court's orders are only binding on the parties to the suit (DoL and the members of the 3 Home Care Organization plaintiffs).
- DoL will **NOT** be enforcing the rule during the appeals process; **however, DoL stated that the effect on non-parties (i.e., parties not included in the suit) is uncertain.**
- DoL stated that the FLSA provides a private right of action, and that if a person in another district (i.e., not D.C.) brings suit against an employer not a party to the suit, a judge may rule that there has been a violation of the DoL rule. Therefore, employers who decide not to comply with the DoL rule, including during the appeals process, do bear risk of a lawsuit.

Litigation Involving DoL Final Rule

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- DoL strongly encouraged employers (including public entities) to make adjustments to come into FLSA compliance, and urged employers and states to continue taking steps to quickly come into compliance with the FLSA.
- If DoL is successful in its appeal, DoL will NOT change its enforcement timelines, meaning it will commence discretionary prosecutions of entities in violation of the rule begin July 1, 2015.

Guidance on DoL Final Rule

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- DoL will look favorably on states that demonstrate good faith efforts to comply with the rule during the appeals process, including amendments to waivers, budget changes, etc.
- Therefore providers are encouraged to familiarize themselves with the provisions of the Final Rule as the penalties for non-compliance could be significant.
- <http://www.dol.gov/whd/regs/compliance/whdfs79g.htm>
- <http://www.dol.gov/whd/homecare/litigation.htm>

Non-substantive Changes

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THINGS THAT PROVIDERS SHOULD KNOW

Waiver Names

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- Change the official name from Home and Community Based Services Waiver for the Mentally Retarded (Arlington) to Comprehensive Aggregate Cap (CAC) Waiver.
- Change the official name from Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled to Statewide Waiver (aka Main Waiver).



Language changes throughout the waiver in Response to Public Comment

Change

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- Address the individuals supported in the waiver as “persons supported.”
- “Per quarter” has been defined throughout the waiver as “once every 3 months”.
- “Plan of Care” has been changed throughout to “Individual Support Plan”.

Language changes throughout the waiver in Response to Public Comment

Change

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- “Waiver year” has been defined throughout the waiver as “calendar year”.
- “30 days” has been defined throughout the waiver as “calendar days” vs. “business days”.
- Changed “ICF/MR” to “ICF/IID” throughout the waiver.
- Changed MR language to IID throughout the waiver.

Substantive Changes to the Waivers

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CHANGES THAT IMPACT PROVIDERS

Individual Cost Neutrality Cap for the Statewide Waiver

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**THIS CAP WILL BE APPLIED ANNUALLY TO
EXPENDITURES FOR INDIVIDUALS IN THE
STATEWIDE WAIVER**

**NOTE: A SEPARATE TRAINING FOR ISCS WILL
BE DEDICATED TO THIS TOPIC**

Individual Cost Neutrality Cap



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- Implemented in the Statewide Waiver an individual cost neutrality cap (cap) based on the average cost of private ICF/IID services in TN. The total cost of all services may not exceed the cap.
- To minimize potential disruption in services, individuals currently enrolled in the Statewide Waiver who were receiving services in excess of the individual cost neutrality cap will transition to the Arlington (renamed “CAC”) Waiver.
- The CAC will continue to have an aggregate cost neutrality cap.

Individual Cost Neutrality Cap



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- As of the cap effective date people enrolled in the Statewide Waiver will have an individual cost neutrality cap of **\$153,416.80 per Waiver Year and ISP Year.**
 - This cap amount will be adjusted each year to maintain consistency with the average cost of private ICF/IID services.
 - State funded services are not subject to the cap.
 - Certain one-time waiver incentive payments are not subject to the cap.
 - There is no provision to exceed the cap.

Waiver Assignment

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- After the waiver changes are approved by CMS, existing spending and cost plan data will be used to determine which people remain in the Statewide Waiver and which people will be moved to the Comprehensive Aggregate Cap (CAC) waiver.
- All class members, former class members and those with services exceeding the established individual cost neutrality cap will transition to the CAC waiver.

Communication

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- TennCare will mail the required 30-day advance written notice to persons supported to inform them of their waiver assignment.
- DIDD will burst a report to each provider based upon active cost plans.
- The report will show the person's current waiver assignment and the person's new waiver assignment (if applicable) at the end of the 30-day advance notice period.
- Note: DIDD expects that the majority of people will remain in their current waivers.

Cap Effective Date Provider Reports

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- DIDD will burst a report to each provider based upon active cost plans. The report will include:
 - Current Waiver Year cap number
 - Current ISP Year cap number
 - Current ISP Date
- People enrolled in the Self Determination and CAC waivers will not have numbers next to their names.

Cap Effective Date Transition to the CAC Waiver

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- On the cap effective date, DIDD will automatically transition people on the list from the Statewide Waiver to the Comprehensive Aggregate Cap Waiver.
- A new PAE or ISP **is not** required.
- Services and supports will continue to be delivered in accordance with the person's current ISP.

Individual Cost Neutrality Cap Calculations



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- Using the information submitted on the ISP, DIDD calculates the **Maximum Billable Amount (MBA)** for individuals in the Statewide Waiver.
 - It is extremely important that ISCs submit ISPs that are within the cap.
- For all periods already closed for billing in Provider Claims Processing (PCP) DIDD uses actual paid/pending amounts.
- For all periods still open for billing DIDD uses the authorized amount of the cost plan.

Individual Cost Neutrality Cap Calculations

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- DIDD assumes providers will bill 100% of the amount authorized.
- If all of the services and funds are not used during the period and PCP is closed for billing the unused funds will become available again.
- Because cost plans change frequently -
 - DIDD will calculate everyone's cap numbers nightly.

Individual Cost Neutrality Cap and Day Services



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- For periods already closed to billing DIDD will use actual paid/pending dollars for Day Services claimed.
- For all periods still open for billing, the cost of Day Services will be calculated using the 5 highest possible claims per calendar week, up to 243 units/year for all authorized Day Service cost plans – for the specific person.

Individual Cost Neutrality Cap



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- ISC's will receive a monthly report showing the cap amount for all people enrolled in the Statewide Waiver.
 - There will be a training for ISCs in the future. The date is to be determined.
- This report will include maximum billable amount for:
 - Waiver Year – past, present and future (if applicable).
 - ISP Year – past, present and future (if applicable).
- The ISC is the provider's first point of contact for cap information for persons supported by the provider.
- The Regional Offices will also have cap information available as questions arise.

Individual Cost Neutrality Cap and Level or Status Changes



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- Timeliness of notification of service level and status changes is **critical**.
- If a cost plan level or service has to be amended which affects a time period that is open in PCP for billing, DIDD must void the entire cost plan back to the start date and the provider has to rebill. **(Cost Plan Voids)**.

Individual Cost Neutrality Cap and Level or Status Changes



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- By policy (80.3.4 Authorization of Services), all services are to be approved in advance.
- Due to PCP calendar publishing and sweep schedules, there is always a grace period of 10 to 17 days prior to today's date not yet open for billing in PCP.
- As long as all service changes are communicated and ISPs are amended promptly as per policy (80.3.4 Authorization of Services) no voids or rebills need to take place.

The Individual Cost Neutrality Cap is Mandatory



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- There are **NO** provisions to exceed the individual cost neutrality cap. The cap cannot be exceeded at the discretion of the ISC, provider or DIDD leadership.
- There are **NO** policy exemptions to the individual cost neutrality cap. Policy 30.1.6 Exemption Process does not apply.
- Each ISP must be submitted with services that can be provided within the individual cost neutrality cap. State funds **WILL NOT** be available to supplement SW waiver ISPs.

Changes Made to Waiver Service Definitions

Waiver Services with Substantive Changes

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- If a waiver service is not listed on this slide or included in this presentation then substantive changes were not made to the service definition, that impact providers.
- Services with substantive changes:
 - Residential Habilitation
 - Semi-Independent Living Services
 - Family Model Residential
 - Medical Residential
 - Intensive Behavioral Residential Support
 - Respite
 - Personal Assistance

Waiver Services with Substantive Changes

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- **Services with substantive changes:**
 - Employment and Day Services
 - Nursing Services
 - Behavior Services
 - Behavior Respite Services
 - Vision Services
 - Specialized Medical Equipment, Supplies and Assistive Technology
 - Support Coordination

New Flexibility in Residential Services

New Language Added in Response to Stakeholder Feedback

52

- Individuals receiving residential and personal assistant services may choose to receive services in a shared living arrangement with other persons who need differing levels of support, differing types of waiver services, or who participate in different HCBS programs, as permitted in state licensure law and regulation, as long as there is a willing, qualified provider who can safely meet the needs of each resident in the home.
- This applies to all residential services.



Shared Living Arrangement Scenarios in Response to Stakeholder Feedback

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- A person receiving Medical Supported Living services may reside with a person receiving Supported Living regardless of level of care.
- A person receiving Medical Residential Services may reside with a person receiving Residential Habilitation.



Shared Living Arrangement Scenarios in Response to Stakeholder Feedback

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- A person receiving Supported Living, Semi-Independent Living, Family Model or Residential Habilitation may reside with a person receiving Community Living Supports (CLS) through the TennCare CHOICES waiver.
- A person receiving Residential Habilitation **may not** reside with someone receiving Family Model or Supported Living.



Out-of-State Residential Services

New Language Added in Response to Stakeholder Feedback

55

- All residential services (with the exception of Semi-Independent Living and Intensive Behavioral Residential Services) may be provided out-of-state for a maximum of 14 days per person per waiver (calendar) year.
- Trips to casinos and other gambling establishments are no longer excluded.

Residential Services:

Added Semi-Independent Living Services (SILS)

56

- In response to public comment and stakeholder feedback, the State added Semi-Independent Living as a service to the Statewide and CAC Waivers.
- The State recognizes that individuals transitioning from 24 hour residential services to SIL may need extra support during the transition period to adjust to the change in services provided.
- The State has added an enhanced reimbursement rate that will be available to providers to help cover the cost of the additional supports provided during this transition period.



Semi-Independent Living Services (SILS)

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- This enhanced reimbursement rate will be available for up to 30 days post transition from 24 hour residential services to SILS. The enhanced reimbursement rate counts against the cap.
- When the transition occurs on the first day of the month, the enhanced reimbursement rate is \$1855.96 for the first 30 days after transition to SILS.
- When the transition does not occur on the first day of the month, the prorated daily enhanced reimbursement rate is \$61.87 for the first 30 days after transition to SILS.

Semi-Independent Living Services (SILS)

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- Additionally, for the one-time Transition to Independent Living Incentive:
 - This is a one-time payment (per person/per provider) for providers who successfully support an individual in transitioning from 24 hour residential services to SILS **and** remaining in SILS for 6 consecutive months.
 - The person must be in SILS at the time the incentive payment is billed.
- **Additional written guidance is forthcoming.**

Family Model Residential Support



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- Per the DoL FLSA Rule, the FMRS provider is restricted from:
 - Determining whether a caregiver chooses to participate in the program.
 - Determining whether a caregiver will bring a particular person supported in his or her home.
 - Directing day-to-day activities of the home.
 - Directing or managing the delivery of services and supports.

Family Model Residential Support



60

- Per the DoL FLSA Rule, the FMRS provider is restricted from:
 - Leasing, finding or purchasing a residence in which the service and supports will be provided.
 - Making frequent visits or phone calls to the home (unless related to the monitoring of service delivery and quality assurance purposes).
 - Instructing the caregiver about particular tasks to perform or ways to fulfill or not fulfill duties.

Medical Residential Services



61

- It was clarified that a nurse may perform non-skilled services including assistance with eating, toileting, grooming and other activities of daily living.



Supported Living Services

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- When approved by special exception, a person supported may live with other family members when the family member is a minor child living with a parent receiving services or spouse of a person receiving services.

Supported Living Services Companion Model Homes

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- Removed the requirement that only the live-in caregiver may reside in the home where the person lives.
- Removed the requirement that only persons receiving Supported Living are allowed to reside in the Supported Living home.
- The implications of this are that for companion model, the companion's spouse, family or significant other can live in the home as long as the person supported agrees.

Intensive Behavioral Residential Support



64

- It was clarified that IBRS may only be selected when alternative approaches have been tried and unsuccessful.
- It was clarified that the ISP must reflect the positive interventions and supports used prior to IBRS, and less intrusive methods of meeting the person's needs that were tried but did not work.



- Changes in terminology within the IBRS service definition:
 - “Target population” changed to “individual”.
 - “Program” changed to “service”.
 - “Admission/Discharge Committee” changed to “Clinical Review Committee”.

Personal Assistance Services



66

- It was clarified that a single personal assistant may provide PA services to more than one individual residing in the same home at the same time, provided each person's needs can be safely and appropriately met.
- It was clarified that only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation must be maintained for each person supported.

Respite

67



- Clarified expectations around hours for Level 2 and Level 3 respite services.
- Level 2 per day reimbursement for people requiring at least 16 and up to 24 hours of respite services in a day.
- Level 3 per day reimbursement for persons requiring 24 hour respite services including awake overnight direct support staff.

Respite

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- Note: Level 1, 2, 3 and 4 respite and combinations thereof are limited to 30 calendar days per calendar (waiver) year per person.
- Note: For hourly respite the use of any part of a day constitutes the use of one of the 30 days per calendar (waiver) year per person.

Employment and Day Services



69

- Service name has been changed to Employment and Day Services.
- Flexibility in scheduling has been added in response to stakeholder feedback; no longer restricted to weekdays between 7:30 am – 6:00 pm.
- **Timeline for implementation: October 1, 2015.**
- Except for students who have graduated prior to May of 2014, Day Services for school aged persons (i.e., under the age of 22) are limited to regular school break periods.

Employment and Day Services



70

- Supported Employment (SE): The preferred option for all persons supported based on each person's needs and preferences.
- Requirements for Supported Employment
 - SE is provided by a job coach that is on-site to support the person, OR
 - When job coach is not needed on site, the provider oversees SE services by conducting a minimum of one contact per week with the person including at least one contact per month at the job site, and must have a job coach available on-call if needed to go to the work site.

Employment and Day Services



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- Note: providers are required to provide the supports consistent with the person's level of need for SE (e.g. Employment- Special Needs or Employment- Individual).
- Supported Employment: incentive payments for vocational related measureable outcomes.
- **Timeline for incentive payments: October 1, 2015.**
- **Additional guidance is forthcoming.**

Employment and Day Services



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- Facility Based (FB) Day Services may be provided:
 - Only when the person supported needs time-limited pre-vocational training and such training is not available on the job site.
 - For persons who, through the person centered planning process, choose to participate in a facility based program in order to -
 - ✦ Focus on the development of individualized and specific skills that will support them in achieving employment and/or community living goals.
 - FB Day Services should be time-limited.

Employment and Day Services



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- **FB Day Services:**
 - Effective immediately, FB Day must allow opportunities for persons supported to engage the broader community, including opportunities to move into more integrated settings.
 - Effective immediately, the opportunity to move to a more integrated setting must be evaluated annually until 7/1/2016.
 - Effective 7/1/2016, FB Day Services will be evaluated and authorized for 6 month periods.

Nursing Services



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- The nurse shall also be responsible for the provision of non-skilled services including eating, toileting, grooming, and other activities of daily living, needed by the person supported during the period that Nursing Services are authorized and provided, unless such assistance cannot be safely provided by the nurse while also attending to the skilled nursing needs of the person supported (which must be documented in writing and approved pursuant to protocol).

Nursing Services



75

- The amount of Nursing Services authorized and provided shall depend only on the skilled nursing needs of the person supported. Additional Nursing Services shall not be authorized only for purposes of providing unskilled needs.
- The practical implication of this language is that Nursing and PA services should **ONLY** be authorized to be delivered at the same time--meaning duplicative services--when it is not possible for the nurse to provide the unskilled assistance while also attending to skilled nursing needs.

Nursing Services



76

- Nursing services may include the provision of services to teach and train the person supported and their family or other paid or unpaid caregivers how to manage the treatment regimen.
 - May be done for the purpose of delegation of specific health care tasks to unlicensed direct support staff – contingent upon activities permissible under State law.
 - Is contingent upon the determination by the provider agency and as permitted by State law.
 - Is contingent upon the nurse's evaluation of the competency of each unlicensed direct support staff.

Nursing Services



77

- A single nurse may provide services to more than one person living in the same residence provided each person's needs can be safely and appropriately met.
- Services apportioned based on an assessment of a person's need and the apportioned amount included in the ISP of each person supported, as applicable.
 - Documentation of service delivery must be kept for each person supported and reflect the total number of shared units of service provided and the specific nursing tasks to be performed for that individual.

Nursing Services



78

- Only one unit of service will be billed for each unit of service provided, regardless of the number of persons supported. Documentation must be maintained for each person supported.
- Further guidance will be issued.

Specialized Medical Equipment Supplies and Assistive Technology

79

- Removed stander or standing table from waiver definition.

Vision Services (CAC Waiver only)



80

- Removed Vision Services.

Behavior Services

81



- It was clarified that the assessment includes assessment and planning and development.
- It was clarified that the Behavior Support Plan (BSP) must be developed through the person centered planning process.
- It was clarified that only Behavior Analysts can conduct behavior assessments and create the BSP.
- Behavior Specialist's duties are defined as:
 - training,
 - data collection and
 - plan implementation.

Behavior Services

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- Conditions under which BA services may be provided and billed in the absence of the person supported are described as follows:
 - Completion of the Behavior Services Assessment Report and development of the Behavior Support Plan (e.g. typing the report).
 - Person supported specific training of staff (except in instances in which the Behavior Analyst can demonstrate appropriate interventions in real time).
 - Presentation of information at human rights committee meetings, behavior support committee meetings and planning meetings.

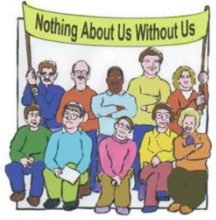
Behavior Respite Services

83



- It was clarified that the service provider shall help plan, coordinate, and prepare for the individual's transition back to residential setting (i.e., discharge planning).
- It was clarified that clinicians providing waiver services are required to monitor and document progress weekly.

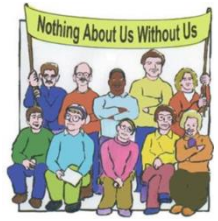
Support Coordination



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- Added language throughout to demonstrate compliance with the Person Centered Planning Rule.
- Appendix D.2: The ISC conducts initial and annual assessments of the individual's experience, in accordance with timeframes outlined in State protocol.

Support Coordination



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- The assessment purpose is to confirm that the setting in which the person supported is receiving services and supports comports fully with the HCBS Settings Rule.
- This includes those requirements applicable to provider-owned or controlled homes, except as justified by the individual's specific assessed need and set forth in the person-centered ISP.

Support Coordination

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- Outlines educational and experience requirements for Support Coordinators.
- Providers ensure employees receive effective guidance, mentoring, and training including training required by DIDD. Effective training includes opportunities to practice support coordination duties.



Support Coordination

87

- New DIDD mandated training for all Support Coordinators and Case Managers as required by the Clover Bottom Exit Plan.
- **Timeline: All ISCs must be trained by 10/31/2015 in order for the agency to receive reimbursement for Support Coordination Services.**



Support Coordination



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- Outlines specific tasks to be completed by the support coordinator such as:
 - General education about the waiver program.
 - General education about rights and responsibilities.
 - Supporting the individual's informed choice of services and supports and the settings in which the services are provided.
 - Providing information regarding the person centered planning process.

Support Coordination



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- Ongoing assessment and identification of the person's preferences for the delivery of services and supports.
- Coordination of benefits with MCOs.
- Timely access to medical and behavioral health services.
- Addressing opportunities for the person to seek employment.
- Notifying provider management if the ISP is not being implemented as well as contacting DIDD when resolution is not achieved.

Safeguards for Persons Supported

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MEDICATION ADMINISTRATION

USE OF RESTRAINTS

Medication Administration and Use of Restraints

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- Updated language related to medication administration and error reporting and use of restraints.

Use of Restraints

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- Must be identified in the person-centered plan.
- Must be done only to ensure the safety of the person or others.
- Plan must indicate what positive interventions are used prior to use of restraint.
- Plan must indicate what has been tried before but did not work.

Use of Restraints

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- Plan must establish timelines for periodic reviews to determine if restraints are still necessary and plans must be reviewed on an individual basis.
- Must ONLY be used as specified in the plan for emergency circumstances and NOT as an ongoing intervention or treatment.
- All staff supporting the person must be trained in its use.

Quality Management Strategy

94

REPORTING TO CMS

PERFORMANCE MEASURES

Quality Monitoring Strategy

Performance Measures



95

- Changes related to annual reporting, per the CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers, released in March 2014, are incorporated throughout. The changes include:
 - Addition, deletions and revisions to the performance measures the State reports to CMS each year.
 - A new requirement that Quality Improvement Plans must be developed and implemented for any performance measure falling below 86% for more than 3 months in a year.
 - A greater emphasis on the Health & Welfare Assurance.

The CMS guidance can be found here: <http://www.medicaid.gov/medicaid-chip-prog>

Quality Monitoring Strategy

Performance Measures

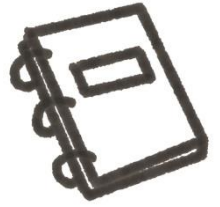


96

- New performance measures were designed to track and report practices that are already in place related to -
 - identifying, addressing and preventing instances of abuse, neglect and exploitation, and
 - demonstrating a strong incident management system,
 - prohibiting the use of restraints, and
 - establishing overall healthcare standards and oversight.

Quality Monitoring Strategy

State Reports to CMS



97

- The State proposed to track and report performance of providers (called the “Qualified Provider Assurance Area”) as one consolidated report including all three 1915(c) waivers instead of submitting three separate reports to CMS annually.
- This change was proposed because DIDD providers are approved to support individuals in all three waivers; therefore there are not separate networks. Under the current system, performance is tracked and any area of noncompliance is reported and counted three times.
- The State believes that the change will lead to a more efficient and accurate measure of provider performance.

Performance Measures

98

Performance Measures



99

- Delete LOC a.i.b.1: Number and percentage of waiver participants who had an annual LOC reevaluation completed within 12 months of their initial evaluation or last annual reevaluation.
- Delete LOC a.i.c.6: Number and percentage of level of care reevaluations made for which level of care criteria were accurately and appropriately applied.
- Per the CMS guidance released in March 2014, these measures need to be tracked by the State but not reported to CMS.
- LOC = Level of Care Assurance Area

Performance Measures

100

- Add QP a.i.a.16: Newly employed (or reassigned) direct support staff serving waiver participants (persons supported) with federal List of Excluded Individuals/Entities (LEIE) checks completed prior to, but no more than 30 calendar days in advance of employment, or a change in assignment to direct support.
- This is an existing requirement that will now be reported to CMS annually.
- QP = Qualified Provider Assurance Area

Performance Measures



101

- Delete SP a.i.b.1. Number and percentage of waiver participants whose Individual Support Plan development included a uniform needs assessment.
- Delete SP a.i.b.2. Number and percentage of waiver participants whose Individual Support Plan development included a risk factor assessment.
- Delete SP a.i.b.3. Number and percentage of waiver participants whose Individual Support Plan development included a medical assessment, where applicable.
- Per the CMS guidance released in March 2014, these measures need to be tracked by the State but not reported to CMS.
- SP = Service Plan Assurance Area

Performance Measures



102

- Delete SP a.i.b.6. Number and percentage of waiver participants whose Individual Support Plans accurately describe the service recipient's desired outcomes, assessed needs, and preferred lifestyles as identified in pre-planning activities.
- Delete SP a.i.b.7. Number and percentage of waiver participants whose Individual Support Plans accurately indicate the current services and supports required to meet identified needs.
- Delete SP a.i.e.1. Number and percentage of waiver participants whose records contained the current Freedom of Choice form.
- Per the CMS guidance released in March 2014, these measures need to be tracked by the State but not reported to CMS.

Performance Measures

103

- Revise HW a.i.9: Number and percentage of **completed** investigations for which abuse, neglect, and/or exploitation was substantiated, total and by type.
- Percentage = number substantiated allegations, total and by type/number of investigations, total and by type.
- The revision was made to clarify that the number reported each month reflects *completed* investigations (not open investigations).
- HW = Health and Welfare Assurance Area

Performance Measures

104

- Revise HW a.i.10: # and % of substantiated investigations, by **total and** type, for which appropriate corrective actions **approved by DIDD** were verified within 45 days of issuance of the investigation report.
- Percentage = # of substantiated allegations for which appropriate corrective actions were verified within 45 days of issuance of the report/total # of corrective actions verified during the reporting period.

Performance Measures

105

- The first minor revision was made to show that the State tracks the total, not only the type, of substantiated investigations.
- The second minor revision was made to show CMS that the State has an active role in reviewing the Plans.
- Note: this is not a new requirement, it reflects existing practice and an existing requirement of providers (Provider Manual 7.4).

Performance Measures

106

- Revise HW a.i.13: Number and percentage of deaths **reviewed and determined** to be of unexplained or suspicious cause.
- Percentage = number of deaths of unexplained or suspicious cause/total number of deaths.
- The revision was made to clarify that the numbers reflect deaths that have already been reviewed.

Performance Measures



107

- Delete HW a.i.14.: This performance measure was duplicative with other measures.

Performance Measures

108

- Add HW a.i.19: Number and percentage of Plans of Correction related to substantiated investigations, required to be submitted by DIDD providers, which are accepted by DIDD after review.
- This performance measure reflects an existing requirement (Provider Manual 7.4) and will be monitored by the DIDD Regional Offices. It is reported to TennCare monthly and reported to CMS annually.

Performance Measures

109

- Add HWa.i.20: Number and percentage of DIDD providers surveyed by DIDD who demonstrate regular review of their critical incidents, as required by DIDD.
- This performance measure is monitored during the Quality Assurance Surveys. It is reported to TennCare monthly and reported to CMS annually.

Performance Measures

110

- Add HWa.i.21: Number and percentage of DIDD providers surveyed who demonstrate they are implementing preventive/corrective strategies when applicable.
- This performance measure is monitored during the Quality Assurance Surveys. It is applicable when providers have substantiated investigations and associated plans of correction. The measure will be reported to TennCare monthly and reported to CMS annually.

Performance Measures

111

- Add HWa.i.22: Number and percentage of behavior support plans (BSPs) developed for waiver participants that comply with State policies and procedures regarding the use of restrictive interventions.
- This performance measure will be monitored by the Director of Behavioral and Psychological Services. It will be reported to TennCare monthly and reported to CMS annually.

Performance Measures

112

- Add HWa.i.23: Number and percentage of reported critical incidents NOT involving the use of prohibited restrictive interventions.
- This performance measure is monitored by DIDD Incident Management. It will be reported to TennCare monthly and reported to CMS annually.

Performance Measures

113

- Add HWa.i.24: Number and percentage of DIDD providers who develop and maintain policies, and implement practices, in accordance with the DIDD Provider Manual and policies that achieve outcomes related to health care management and oversight.
- This performance measure is monitored during the Quality Assurance Surveys. It will be reported to TennCare monthly and reported to CMS annually.

Performance Measure

114

- Add FAa.i.4: Number and percentage of rates approved that are consistent with the approved rate methodology throughout the five year waiver cycle.
- This performance measure is tracked and reported by TennCare.
- FA = Financial Accountability Assurance Area

Financial Accountability

115

Independent Audit Requirement

116

- Update Independent Financial Audit requirement from \$500,000 to \$750,000:
 - “The Department of Intellectual and Developmental Disabilities (DIDD) requires providers receiving \$750,000 or more in aggregate state and federal funds to obtain an independent audit of the organization and to submit copies of the independent audit to the Tennessee Office of the Comptroller and to the DIDD Office of Risk Management and Licensure.”

Independent Audit Requirement

117

- Note: many public commenters noticed that two amounts are listed in this section. That is not a discrepancy; it is because there are two different thresholds for two different audits:
 - DIDD has adjusted the threshold for a FAR audit. Going forward all providers who receive at least \$500,000 in funding will have a FAR audit.
 - An Independent Financial Audit is required for providers who receive at least \$750,000 in funding. This change was made by the Office of the Comptroller.
- Both of these audits are based on the amount of state and federal funding the provider receives, not just waiver dollars.

Questions and Answers



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- If you haven't already done so, you may submit your questions by entering it in the chat box.

For Assistance Contact



119

- Behavior Services and IBRS: Bruce.Davis@tn.gov
- Billing/Payment Maintenance Issues: [DIDD Billing.ACR@tn.gov](mailto:DIDD_Billing.ACR@tn.gov)
- Cap Calculation Maintenance Issues: Steve.Lundwall@tn.gov
- Cost Plan Maintenance Issues: [DIDD Business.Services@tn.gov](mailto:DIDD_Business.Services@tn.gov)
- CMS Final Rule: Hollie.Campbell@tn.gov
- Day Services: Amy.Gonzalez@tn.gov
- Nursing Services: Bill.Feldhaus@tn.gov
- Residential Services: Barbara.DeBerry@tn.gov or Kimberly.J.Black@tn.gov
- Support Coordination: Courtney.Kelly@tn.gov
- Supported Employment: Amy.Gonzalez@tn.gov
- Therapeutic Services: Karen.Wills@tn.gov
- Quality Monitoring: Pat.Nichols@tn.gov